



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights of privacy regarding my protected health information. I understand that, when applicable, this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and clinician certifications

I understand that it is my responsibility for all payments to my provider at Rise Center for Psychology. I hereby consent to the release of any medical information necessary to aid in the processing of insurance claims if necessary. Additionally, I agree to allow the offices of Rise Center for Psychology to send invoices over the email I supply below.

Signature of Client _____ **DATE** _____
 (If over 12 years old)

Signature of Parent/Guardian _____ **DATE** _____

If we need to contact you, please list the number(s) we may use to contact you:

Client’s Home# (____) _____ Cell# (____) _____
 Work# (____) _____ May we leave a message ? Y/N _____
 Email address: _____

Children Under Age 18

Mother’s Home# (____) _____ Cell# (____) _____
 Work# (____) _____ May we leave a message ? Y/N _____
 Email address: _____

Father’s Home# (____) _____ Cell# (____) _____
 Work# (____) _____ May we leave a message ? Y/N _____
 Email address: _____

I have read and understand this document, as well as understand the Financial Agreement and Office Policy, and agree to these provisions.

Signature of Client _____ **DATE** _____
 (If over 12 years old)

Signature of Parent/Guardian _____ **DATE** _____